

**KanCare Advisory Council
Curtis State Office Building- Room 530, Topeka, Kansas
Minutes of June 11, 2014**

Council Members Present:

Dr. Michael Kennedy
Chairman Larry Martin
Jamie Price
Mark Hinde
Beth Simpson
Edward Nicholas
Senator Mary Pilcher-Cook
Lora Key
Njeri Shomari
Representative Susan Concannon

Council Members Absent:

Representative Jerry Henry

Council Members Attending Via Phone:

Walter Hill
Allen Schmidt

Other Participants:

Secretary Robert Moser, M.D., Kansas Department of Health and Environment
Acting Secretary Kari Bruffett, Kansas Department for Aging and Disability Services
Susan Mosier, M.D., Acting Director of KDHE Division of Health Care Finance / Medicaid Director

Other Participants Absent:

Lt. Governor Jeff Colyer, M.D.

Welcome – Chairman Larry Martin

Larry Martin opened the meeting. The agenda for the meeting was unanimously approved by the Council as published

Review and Approval of Minutes from Council Meeting, March 26, 2014.

The meeting minutes were unanimously approved by the Council as published. Allen Schmidt made a motion to approval the meeting minutes and Ed Nicholas seconded the motion.

Updates on KanCare with Q & A

Amerigroup Kansas – Thomas Killian

Thomas Killian provided a brief update on Amerigroup.

- I/DD Implementation – Overall feels I/DD implementation has gone smoothly with the same operational system in place. Individual issues are followed up directly with the I/DD provider representative.
- Focused on cleaning up residual issues from 2013 and moving forward with a 2014 focus.
- Implementing a new web provider portal. In the process of performing provider education training. Continue to provide monthly educational provider forums.
- Continuing on work related to the health home program implementation and gone thru the readiness review with the state. Moving to next step, working with providers on the contracting activity and getting those providers wishing to participate in the network.

Questions and Answers:

None.

Sunflower State Health Plan – Mike McKinney

Mike McKinney provided a brief update on Sunflower State Health Plan.

- Continue to make changes to our staff with additional nurses, case managers and changed some of the leadership placing an emphasis on take care of the patients.
- I/DD – Kansas is a national model in I/DD with everyone watching the outcome. Sunflower has concentrated efforts and personnel on this population. Contacted and evaluated everyone on the underserved list. One of the programs picked up on I/DD is employment, not just counseling or completing applications, but trying to encourage members to move towards independence and seek employment out in the community.
- Continuing to work on the health homes implementation geared to treat the whole person not just the illness.
- Reminded group to refer to statistics in the handout and make judgment by statistics not just stories.

Questions and Answers:

Allen Schmidt – When reviewing the Executive Summary, chart on pg 7 referring to value of services avoided. Earlier talking about adding individuals to independent living; are the members and dollars on the chart related to this?

Mike McKinney – That large number reflects expenditure made on services not covered under regular Medicaid. It is actually a measure of the increase services. We call it in lieu of services. We provide these services from keeping individuals from going to the hospital.

Allen Schmidt – This would be like avoiding ER visits? Cost avoided?

Mike McKinney – Yes, and the way to avoid those is not by blocking them from going to the hospital but helping taking care of their needs prior to needing a ER visit.

UnitedHealthcare Community Plan – Tim Spilker

Tim Spilker provided a brief update on UnitedHealthcare.

- Member Outcomes: a) Member engagement = Cost management; b) HEDIS and pay for performance activity: Physical health measures; Behavior Health (BH)/Waiver measures and Long term care (LTC) measures; c) Employment: Empower Kansas and WORK program.
- Health Homes: a) Received provider readiness reviews; b) Engaging CHMCs through health

home pilot; c) Preparing operations and infrastructure for 7/1 member enrollment and 8/1 service go live.

- Provider Engagement and Claims Payment: a) Continue focused efforts to address remaining global provider issues; b) Aggressively addressing provider concerns identified through State's provider experience survey; c) Continued strong performance on DD: Denial rates below 2%, turnaround time 5-7 days, 60% complete on underserved list, intense provider outreach and continued clinical engagement
- IronKids Fun Run completed in Lawrence, KS with a donation of \$3,000 to Boys and Girls Club.
- 60% complete on underserved list.

Questions and Answers:

Mike Kennedy – In reference to Health Homes: How are providers educated about health homes and the mechanism for payment?

Tim Spilker – Providers are educated by weekly education systems and through the discussions basically everything is covered (mechanism, contracts, etc).

Lora Key – To be a Health Home partner will that be an addendum to the contract?

Tim Spilker – Have a very simple Health Homes contract addendum that literally attached to the existing contract. Health Homes itself will not affect the fee schedule.

Health Homes Update – Samantha Ferencik

Samantha Ferencik provided an update on Health Homes.

Implementation: Health Homes for certain KanCare members will be implemented July 1, 2014. a) People with serious mental illness (SMI) – approximately 36,000 eligible; b) People with asthma or diabetes and at risk for another chronic condition – approximately 38,000 eligible.

Kansas Goals: Kansas has set four goal for Health Homes: 1) Reduce utilization associated with avoidable (preventable) inpatient stays; 2) Improve management of chronic conditions; 3) Improve care coordination; 4) Improve transition of care between primary care providers and inpatient facilities.

State Plan Amendments: The two State Plan Amendments which the Centers for Medicare and Medicaid (CMS) must approve to authorize federal match for the program were submitted in early May. Monthly discussions with CMS indicate there should be no issues with approval. Upon approval of the July 1 implementation date, Kansas will receive 90/10 enhanced match for the first 8 federal quarters.

Kansas Model: 1) Individual and family supports; 2) Referral to community and social supports; 3) Care coordination; 4) Comprehensive transitional care; 5) Health promotion; 6) Comprehensive care management.

Building Networks: Interested providers have submitted Preparedness and Planning Tool (PPT) – a self-assessment of readiness. MCOs are initiating discussion with interested providers. 118 PPTs have been received – all request to work with all three MCOs. Subcontracting providers.

Provider Engagement and Education: 50+ presentations to providers and associations. Two forums (400 attended) in April and July 2013. Regular Stakeholders meetings since April 2012. Twice-monthly webinars since March 2014. Six regional providers meetings – April 2-9, 2014. Final Stakeholder meeting June 3, 2014. Launch Learning Collaborative after July 1, 2014.

MCO Readiness Reviews: On site visits with MCOs May 20-22, 2014. State team reviewed enrollment processes, provider network and contacting, plans for service delivery, monitoring, quality measurement and evaluation and billing and payment processes.

HIT Technical Assistance: Contracted with Kansas Foundation for Medical Care (KFMC) to provide

technical assistance to help providers plan for and implement EHRs. Many don't qualify for meaningful use. Health Home Partners must have a plan within 60 days for interoperable EHRs and connecting to an HIE.

Health Home Payment: Each MCO will be paid a retrospective per member per month (PMPM) payment for each member enrolled in a Health Home, once a service is delivered. One PMPM payment, regardless of number of services provided in a month. If no Health Homes services are provided in a month, no payment is made to the MCO. Health Home payments do not replace existing KanCare payments to providers. KanCare payments to MCOs are offset if the MCO is receiving a HH payment for the member.

Health Home Payment: MCO will contract with Health Home Partners (HHP) to provide some or all of the six core Health Home services. Number and type of services will be negotiated and described in the contract between MCO and HHP. PMPM Payment from MCO to HHP. Other arrangements can be negotiated (pending KDHE approval).

Payment Principles: State Health Home payments to MCO are structured to be adequate in ensuring quality services are sustainable. MCO payments to HHPs will be structured to be adequate in ensuring quality services are sustainable. State Health Home payments to the MCOs are actuarially sound as defined by the American Academy of Actuaries.

Transformative Process: Changing how the systems deals with patients-whole person.

Encouragement of local collaborations. Moving more providers to robust use of HIT. Bundled payment for a set of services that encourage and improve health. Active engagement of patient in self-management of conditions.

Questions and Answers:

Mary Pilcher Cook – Needing more clarity on why Health Homes is needed. How is this different from what is already being provided and how are we going to ensure this is not duplication of services?

Samantha Ferencik – We see some populations who are receiving services under KanCare but have needs that can be preventable prior to hospitalization. We are looking at providing more intense additional services.

Mary Pilcher Cook – Currently are the MCOs responsible for this?

Samantha Ferencik – When we review the data there are still folks who are not receiving the services and this is an opportunity for us to provide these services. After this meeting I can refer you to material that will provide additional information in this area.

Susan Mosier – One of the other things with regards to services is when we look at the payment structure. One of things we do is reduce the payment. We do expect the MCOs to do care coordination but we actually reduce the main KanCare member per month payment for that coordination of care and administration services and that is not duplicated in terms of payment with the amount of the PMP and that is provided for those 6 core services.

Mary Pilcher Cook – Concerned mostly on oversight and if these services are duplicated in health homes.

Susan Mosier – In other states we have seen great reduction in in-patient hospitalization and visits in ER. Our neighboring state of Missouri is 1 ½ years in and have seen excellent results.

Michael Kennedy – Who has the burden of proof? So who is the one monitoring to see if there is a duplication and what is the mechanism of that and does that create another layer in oversight to make sure there is no duplication?

Susan Mosier – That is the state's role and responsibility to ensure that we are not duplicating additional bureaucracy.

Kari Bruffett – Health homes is seen as part of KanCare and works through the MCOs. The state will hold the MCOs accountable for these outcomes. Establishing a partnership between the MCOs and the providers trying to move more of that care coordination closer to the patient/consumer.

Michael Kennedy – Concern is the burden will be shifted to the providers to provide data to demonstrate the lack of communication of services and therefore would have another layer of complication. This is the reason I raised the question.

Secretary Moser – We are wanting to make this part of the day to day work and not adding a burden to the provider. Wanting to reduce the cost of care in the long run.

Michael Kennedy – This is the way to go and holds everyone accountable. Applaud the state for moving in this direction.

Walt Hill – Very supportive of this. What kind of community organizations can be Health Home partners? Also, quick overview of relationship of health home partner and some of our needy individuals.

Samantha Ferencik – This information can be found on the Health Homes website and is under the state plan amendments. Providers who are eligible are listed in this section as well. Must be enrolled as a KanCare provider to be a health home provider.

Walt Hill – Would a health home provider need to contract with a partner or can they contract directly with the MCO?

Samantha Ferencik – Currently we are asking those interested to submit a tool so that the state can have a record of their interest and some insight into their current capabilities. If they are not meeting these requirements they will not be able to be a health home partner. However, they may be able to have a secondary contract with an established health home contractor.

Walt Hill – How will the Health Home partners work with TCMs?

Samantha Ferencik – Will work different in different situations. We have made the guarantee with TCMs if you are I/DD and are eligible under the SMI population the Health Home partner must contract with that case manager.

Walt Hill – Would that be the case for the chronic care spa?

Samantha Ferencik – Have not mandated this. If there is a capable TCM who can get a subcontract that would be good.

Beth Simpson – Questions on how this is going to work. Letter to be mailed out 7/1-7/31 – is this the letter to respond or the billing starts 7/1?

Samantha Ferencik – The letters will go out 7/1. A person can opt out anytime and can opt back in anytime. Billing for services we believe will begin 8/1.

Beth Simpson – If they don't respond and a particular agency is not aware that one of their individuals is targeted in Health Homes; how does that work?

Samantha Ferencik – Implementation date is 7/1. If the letter arrives and they do not respond the individual is automatically in Health Homes. The health home partner they are assigned to or the health home coordinator will reach out to the individuals to ensure all of the doctors are aware of what is happening.

Beth Simpson – For all individuals identified who will benefit, 36,000 SMI and 38,000 asthma or chronic conditions; how do those number crossover with the other waivers?

Samantha Ferencik – I don't have the other numbers with me but I/DD make up less than 4%.

Beth Simpson – For I/DD folks with dual diagnosis, how do you determine who is primary if they are included in the mental health?

Samantha Ferencik – We discussed this issue with the MCOs in the readiness reviews. Have to have a primary diagnosis of SMI at some point in their medical history to be qualified as Health Homes. The provider will receive communications from the MCOs giving information on why the individual does not meet the requirements or a letter back stating they are already in a Health Homes or a letter stating this person is eligible and thank you for referring them and this is where they will be placed. At that point, the letter will be sent to the individual and let them know where they have been assigned and have a choice to stay or move out.

Beth Simpson – Will KMAP have a tool to look up a client?

Kari Bruffett – This is an excellent suggestion.

Beth Simpson – For the targeted case manager when there is a duplicate for IDD population; where is the letter going to go and is there a secondary notification if the letter disappears?

Samantha Ferencik – Do not have plans to send out a second letter if the first one disappears. If an individual has a guardian, the letter will be sent to them

Allen Schmidt – When dealing with the health home partners and working with the target case providers, is the guarantee applicable or not applicable to the chronic care group?

Samantha Ferencik – Yes, it is applicable. The guarantee rates are available on the Health Homes website.

Mary Pilcher Cook – Believe it was said there is a federal 90/10 match for the first eight quarters; what happens after that?

Samantha Ferencik – We will be responsible for figuring something out on how to split this. The long term goal is this will reduce long term utilization and reduce costs. We are hoping this kind of buffer will help bring down these costs. Secondly, a lot of these individuals, if we are doing this right, will transition out of Health Homes because their diabetes or asthma will be under control. No suggestion has been received that Health Homes is going away after eight quarters.

Mike Randol – It will revert to FMAP which we received currently for Medicaid funding 57% federal and 43% state.

Update on Employment First Initiative and Employment Pilots – Mary Ellen Wright

Mary Ellen Wright provided an update on Employment First Initiative and Employment Pilots. The two pilots are designed to promote employment with youth and adults with disabilities.

The Supplemental Security Income (SSI) Employment Pilot is designed to provide individuals receiving SSI who need long term supports with the supports necessary to connect them to the employment. The SSI Employment Support Pilot will promote employment for individuals with Intellectual /Developmental Disability (I/DD) and Physical Disability (PD) on the I/DD and PD Home and Community Based Services (HCBS) waiver waiting lists by providing personal and employment support services for individuals who are employed. Pilot participants will be given a monthly allocation, capped at \$1,500/month, to purchase the services they need to live and work in the community. Participants in the pilot will receive medical coverage through KanCare. The SSI Employment Support Pilot will target up to 400 individuals between the ages of 16 and 60 who are currently on the HCBS I/DD or PD waiting lists. Services include benefits planning, personal care and employment supports services, Medicaid coverage and referral for assistance to obtain employment.

The Social Security Alternative Pilot will provide health care and assistance to obtain employment as an alternative to Social Security for individuals seeking a disability determination. Those who need longer term supports will be given a monthly allocation, capped at \$1,500/month, to purchase the services they need to live and work in the community. The Social Security Alternative Pilot is designed for a maximum of 200 individuals who meet the Social Security Administration (SSA) criteria for disability, but who have not yet been determined eligible for Social Security (SSI/SSDI) cash benefits or Medicaid coverage. Services include Benefits Specialists available to discuss this option and alternatives to this option available to the individual, personal care and employment support services, Medicaid-like coverage until they become employed and obtain employer-sponsored health insurance and referral for assistance to obtain employment.

Questions and Answers:

Edward Nicholas – How were the individuals chosen for these pilots?

Mary Ellen Wright – They will volunteer for the pilot. We are coordinating with Kansas Department of Aging and Disability Services (KDADS) to obtain the waiting list, look at the age and outreach to individuals to inform eligibility for this program. Also coordinate with Department of Children and Families (DCF) rehabilitation.

5-5-5: Putting Kansas With Disabilities On the Road to Success

The cabinet Secretaries of the five Kansas governmental agencies have committed to this multi-year, multi-million dollar collaborative to substantially increase the numbers of Kansans with disabilities who report their own earned income as their primary means of support and self-sufficiency. The project is a 5 year, \$25 million employment initiative of the following 5 state agencies: Department for Children and Families; Department for Health and Environment; Department on Aging and Disability Services; Department of Commerce; and Department of Corrections. Under the leadership of Governor Brownback and the heads of the five agencies, Kansas will implement the first and best solution to the plight of Kansas' citizens with disabilities getting and keeping a job. This collaborative effort will be the first of its kind in Kansas and will combine the agencies' resources, funding, expertise, and community-based provider networks to move our state forward.

Update from KanCare Ombudsman – Kerrie Bacon

Kerrie Bacon provided an overview of the KanCare Ombudsman Quarterly Report, 1st Quarter. 2014 and KanCare Ombudsman Quarterly Report 2nd Quarter to date, 2014 Data Information-Rvsvd for CMS June 11, 2014. The Ombudsman's office hired Ruth Buffalo as the Volunteer Coordinator to create a volunteer program across Kansas to assist members with questions and issues. The data project for the tracking will be in effect prior to the end of the 2nd quarter. Phone calls are down 70% for 2nd quarter at 321 compared to 500 in first quarter. The top five issues for calls received are related to Medicaid eligibility, billing, medical services, durable medical equipment, and appeals/grievances.

Review of KanCare Executive Summary – Acting Director Susan Mosier, Division of Health Care Finance, Kansas Department of Health and Environment

Susan Mosier reviewed the KanCare Executive Summary dated 6.10.14. Pay for Performance Measures – Year One included 6 process measures. 3% withheld from the capitation payments in year 1 and each of the MCOs earned back approximately 2%. The Pay for Performance will change this year and moving forward and will be focused on quality of care and outcome measures. Year 2 Pay for Performance will focus on physical health measures, Behavior Health (BH) /waiver measures and long term care (LTC) measures. The performance measures can be found on the KanCare website www.kancare.ks.gov - policies & reports/KanCare quality measurement/performance measures. The KanCare Quarterly Reports can be found on the KanCare website - policies and report section. The quarterly report Section XIII has been expanded to include information on the wait list management for individuals with physical disabilities, report on RAS, and claims adjudication statistics. A request was received to provide an assessment of 2013 in terms of how KanCare is meeting goals. At this time we are collecting and finalizing data and will send report prior to the September meeting for review and discussion at the meeting.

Update on I/DD Implementation and Elimination of the Underserved List– Acting Secretary Kari Bruffett, Kansas Department for Aging and Disability Services

Secretary Bruffett provided an update on I/DD Implementation. Intellectual/Developmental Disability (IDD) billing data through June 1 show more than \$96 million has been billed for Home and Community Based Services (HCBS)/IDD and more than \$93 million has been paid. I/DD Targeted Case Management (TCM) have billed \$3.4 million and over \$3.3 million have been paid.

RASL as of May 15, 2014, I/DD waiver program had 8,736 participants receiving services. There are 3,141 on the waiting list for services. In January KDADS sent out letters to 1,740 individuals on the “underserved” list, their families and guardians. The letters explained the assessment process, and asked individuals or their loved ones to indicate their needs by responding to an attached form and to return the document to KDADS. This form asked them to clarify the immediacy of their need for additional services (within 30 days, within a more extended time frame, or not at all.) Their responses determined how quickly the MCO care coordinators responded with appropriate person-centered planning for those consumers. Then their MCO care coordinators began working with their targeted case managers to plan their care, beginning with those who indicated immediate need. Of the original 1,740 individuals on the list, 763 had not responded by March and so the agency sent them a second letter. Their Community Developmental Disability Organizations also corresponded with them about the need to respond to the agency’s inquiry. MCOs also reached out. To date, 1,059 have responded; 31 percent requested additional services within in 30 days and are in the process of being reassessed and having new plans of care written, 21 percent indicated they do not need any services at all, and approximately 48 percent indicated that they believe they will want additional services at some time in the future. Everyone on this list has been, or will be, assessed, regardless of how they responded or whether they responded. (At the meeting, each MCO indicated they had completed all or nearly all assessments for those requesting additional services.) So far only six members have filed a formal appeal of their assessments. This is significant because it tells us the MCOs and targeted case managers are working in collaboration with individuals and their families and guardians to provide what each person needs. The plan is to have resolved all requests for more services by the end of the summer, and to have plans of care and the resources in place to be able to provide future services when they are needed. By the end of the summer, there will be no “underserved” list.

Final Rule on HCBS Settings: CMS issued a final rule March 17, 2014 for HCBS services that requires states to review and evaluate HCBS settings, including residential and non-residential settings. States are required to ensure all settings comply with the new requirements and analyze all settings where HCBS participants receive services to determine if current settings comply with the final rule. CMS expects all states to develop a Transition Plan for each waiver that provides assessment, strategies, and timelines for meeting with the new rules. KDADS has created a transition plan to assess compliance with the HCBS settings rule and identify strategies and timelines for coming into compliance with the new rule. The federal regulation for the new rule in 42 CFR 411,301(c)(4)-(5), and more information on the rules can be found on the CMS website at www.medicaid.gov/hcbs.

The public comment sessions will be held June 16-19, 2014 from 12:00-1:30 pm and from 5:30-7:00 pm in the following locations:

- Monday, June 16th – WSU Metroplex, Wichita, Kansas
- Tuesday, June 17th – Holiday Inn and Suites, Overland Park, Kansas
- Wednesday, June 18th – Holiday Inn Holidome, Lawrence, Kansas
- Thursday, June 19th – Holiday Inn Express, Pittsburg, Kansas

Additional public comment sessions (conference calls) are available:

For Consumers

- Wednesday, July 2, 2014 from 12:00-1:00 p.m.

For Providers

- Monday, June 23, 2014 from 11:00-12:00 p.m.

- Tuesday, July 15, 2014 from 10:00-11:00 a.m.

We expect to post the initial transition plan this week. (Update: It was posted 6/14)

I/DD and traumatic Brain Injury (TBI) Waiver Renewals: The State of Kansas and the Centers for Medicare and Medicaid Services (CMS) have agreed the best way for Kansas to achieve compliance with the new HCBS settings rule is to request a 90-day extension of its I/DD and TBI waivers until September 30, 2014. This will enable the state to successfully complete and ensure an appropriate amount of time is available for the development of a transition plan to implement the new HCBS settings rule, to conduct a 30-day public comment period on the state's proposed transition plan, to compile public comments for consideration and modify the plan based on public comment as appropriate and to compile a summary of the disposition of the comments that will be included in the transition plan in the waivers. The transition plan will be incorporated into the TBI and I/DD waivers for renewal prior to September 30, 2014.

Questions and Answers:

Beth Simpson – Clarification: 31% needed services within 30 days and the hope is to be off list by August 1st?

Kari Bruffett – Yes, everyone should be off of this underserved list by the end of summer. Either they will be off the list because of starting services or have a future date for starting services or a plan of care in place or have decided these additional services are no longer needed and/or have an alternative developed with the targeted case manager and MCOs.

Beth Simpson – Could you provide a number of how many completed currently?

Kari Bruffett – Dr. McKinney stated Sunflower's list is complete, Tim Spilker stated UnitedHealthcare has 5 remaining on the list, and Thomas Killian stated Amerigoup is close to 100% complete.

Beth Simpson – On the pharmacy side just have not seen a lot of residential folks and was just curious.

Kari Bruffett – Assessments complete only.

Beth Simpson – 6% were appeals?

Kari Bruffett – A total of 6 people appealed at this point. The individual circumstances for the appeal is not known.

Chairman Larry Martin thanked everyone for attending the meeting and adjourned.

Next Meeting of KanCare Advisory Council – September 25, 2014, 2:00-3:30 p.m., Curtis State Office Building, Room 530